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Office of Administrative Law Judges
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Issue Date: 24 February 2005

In the Matter of:
HABERT J. JOHNSON
Claimant

Case No.: 2004 BLA 5902

v.

DRUMMOND COMPANY, INC.
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party in Interest

Appearances:
Mr. Patrick Nakamura, Attorney
For the Claimant

Ms. Katie Vreeland, Attorney
Ms. Laura Woodruff, Attorney
For the Employer

Before:
Richard T. Stansell-Gamm
Administrative Law Judge

DECISION AND ORDER – DENIAL OF BENEFITS

This matter involves a claim filed by Mr. Habert J. Johnson for disability benefits under the Black Lung Benefits Act, Title 30, United States Code, Sections 901 to 945 ("the Act"). Benefits are awarded to persons who are totally disabled within the meaning of the Act due to pneumoconiosis, or to survivors of persons who died due to pneumoconiosis. Pneumoconiosis is a dust disease of the lung arising from coal mine employment and is commonly known as "black lung" disease.

Procedural Background

First Claim
(DX 1)[1]

Mr. Johnson filed his first application for black lung disability benefits on September 19, 1994. After reviewing the evidence, the District Director denied his claim for benefits on February 17, 1995 for failure to establish the presence of pneumoconiosis and total disability. Mr. Johnson did not appeal the decision.

Second Claim
(DX 2)

Mr. Johnson filed his second application for black lung disability benefits on November 12, 1998. After reviewing the evidence, the District Director denied his claim for benefits on February 19, 1999 for failure to establish the presence of pneumoconiosis and total disability. Mr. Johnson did not appeal the decision.

Third Claim
(DX 3)

Mr. Johnson filed his third application for black lung disability benefits on March 7, 2000. After reviewing the evidence, the District Director denied his claim for benefits on June 2, 2000 for failure to establish the presence of pneumoconiosis and total disability. Mr. Johnson contested the decision on August 21, 2000.[2] The case proceeded to a conference in which a proposed order and memorandum was issued on December 12, 2000, denying Mr. Johnson's claim for failure to establish the presence of pneumoconiosis and total disability. After the submission of additional evidence, the District Director issued a proposed decision and order, denying Mr. Johnson's request for modification on June 18, 2001. On September 20, 2001, Mr. Johnson filed another application for black lung disability benefits. Because less than one year had passed since his previous claim had been denied, the application was treated as a request for modification; however, since Mr. Johnson did not submit any additional medical evidence, the District Director denied his request for modification on December 3, 2001. Mr. Johnson did not appeal the decision.

Fourth, and Present Claim
(DX 4)

Mr. Johnson filed his fourth application for black lung disability benefits on January 16, 2003. On June 12, 2003, the District Director issued a notice indicating that Mr. Johnson would not be entitled to benefits if a decision was issued at that time because he had not established that

[1]The following notations appear in this decision to identify exhibits: DX – Director exhibit; CX – Claimant exhibit; EX – Employer exhibit; ALJ – Administrative Law Judge exhibit; and TR – Transcript.

[2]It appears that the District Director treated his letter of appeal received more than 30 days after a decision had been issued as a modification request.

he was totally disabled; however, the parties were provided an opportunity to file additional evidence (DX 19). After a review of additional evidence, the District Director denied benefits to Mr. Johnson on January 12, 2004. Although Mr. Johnson had established the presence of pneumoconiosis, he failed to prove that he was totally disabled (DX 30). Though counsel, Mr. Johnson appealed the adverse decision on January 23, 2004 (DX 31). As a result, the case was forwarded to the Office of Administrative Law Judges on March 5, 2004 (DX 34). Pursuant to a Notice of Hearing, dated August 23, 2004, (ALJ I), I conducted a hearing in Birmingham, Alabama on November 9, 2004. Mr. Johnson, Mr. Nakamura, Ms. Vreeland and Ms. Woodruff attended the hearing.

Evidentiary Discussion

At the hearing, in response to the Claimant's submission of Dr. Cappiello's positive interpretation of an October 1, 2003 chest x-ray, Employer's counsel sought the opportunity to submit rehabilitative evidence from Dr. Goldstein who found the film to be negative. I kept the record open for thirty days for the submission of that evidence. On December 9, 2004, Employer's counsel sent me a comment from Dr. Goldstein about his interpretation, dated November 30, 2004, which I now admit as EX 4.

Accordingly, my decision in this case will be based on all the evidence in the record: DX 1 to DX 34, CX 2, CX 3, and EX 1 to EX 4.

ISSUES

1. Whether Mr. Johnson in filing a subsequent claim on January 16, 2003 has demonstrated that a change has occurred in one of the conditions, or elements, of entitlement, upon which the denial of his prior claim was based in December 2001.

2. If Mr. Johnson establishes a change in one of the applicable conditions of entitlement, whether he is entitled to benefits under the Act.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Stipulations of Fact

At the hearing, the parties stipulated to the following facts: a) Mr. Johnson had post-1969 coal mine employment; b) Mr. Johnson's length of coal mine employment was at least fifteen and a half years; c) Drummond Company, Inc., is the responsible operator in this case; and, d) Mrs. Roberta Johnson is a dependent for the purpose of augmenting any benefits that may be payable (TR, pages 8 to 10).

Preliminary Findings

Born on February 3, 1937, Mr. Johnson married Mrs. Roberta Johnson on September 29, 1956. He started mining coal for Drummond Company in 1974 and retired in 1994. His coal

mine employment was interrupted at least twice for a few years when he was laid off. During his coal mining career, Mr. Johnson worked as a common laborer, belt installer, material helper, motorman, timber helper and track man. At the time he stopped mining coal in 1994, he was a track man. As a track man, Mr. Johnson set up rails by dragging oak creosote ties, putting them under the rails and using a hammer to put spikes through the oak ties, eventually setting the rails. He and his partner moved the heavy rails with a rocker bar; the wood ties weighed up to 60 pounds. His job also involved repairing, cutting, and welding track rails, several times a week. Mr. Johnson had to carry numerous tools for his work and move welding gas tanks, weighing up to 100 pounds. When welding, Mr. Johnson wore a respirator. On occasion, Mr. Johnson was assigned common laborer tasks, which included setting timber, lifting rocks, and breaking the belt line. Mr. Johnson stopped mining coal when he became sick and was having trouble breathing. Mr. Johnson also worked as a janitor in a foundry, clearing and cleaning floors of grinding material (DX 5, DX 10, TR, pages 24 to 32 and 34 to 36).

Mr. Johnson never smoked cigarettes. Presently, Mr. Johnson has trouble breathing, especially at night. He also becomes tired when walking. Mr. Johnson sees Dr. Pennell every three months for treatment of his breathing problems. Dr. Hawkins prescribed an inhaler and Dr. Goldstein informed Mr. Johnson that he may have heart problems. He also has arthritis and high blood pressure, conditions for which he is undergoing treatment. Mr. Johnson is able to walk half a block to a block and engages in minimal house chores (TR, pages 32 to 34, 39 to 41, and 46 to 49).

Issue #1 – Change in Applicable Condition of Entitlement

Any time within one year of a denial or award of benefits, any party to the proceeding may request a reconsideration based on a change in condition or mistake of fact made during the determination of the claim. 20 C.F.R. § 725.309 (c) and 20 C.F.R. § 725.310. However, after the expiration of one year, the submission of additional material or another claim is considered a subsequent claim which will be considered under the provisions of 20 C.F.R. § 725.309 (d). That subsequent claim will be denied unless the claimant can demonstrate that at least one of the conditions of entitlement upon which the prior claim was denied ("applicable condition of entitlement") has changed and is now present. If a claimant does demonstrate a change in one of the applicable conditions of entitlement, then generally findings made in the prior claim(s) are not binding on the parties 20 C.F.R. § 725.309 (d) (4). Consequently, the relevant inquiry in a subsequent claim is whether evidence developed since the prior adjudication would now support a finding of a previously denied condition of entitlement.

The court in *Peabody Coal Company v. Spese*, 117 F.3d 1001, 1008 (7th Cir. 1997) put the concept in clearer terms:

> The key point is that the claimant cannot simply bring in new evidence that addresses his condition at the time of the earlier denial. His theory of recovery on the new claim must be consistent with the assumption that the original denial was correct. To prevail on the new claim, therefore, the miner must show that something capable of making a difference has changed since the record closed on the first application.

In adjudicating a subsequent claim by a living miner in which the applicable conditions of entitlement relate to the miner's physical condition, I focus on the four basic conditions, or elements, a claimant must prove by preponderance of the evidence to receive black lung disability benefits under the Act. First, the miner must establish the presence of pneumoconiosis.[3] Second, if a determination has been made that a miner has pneumoconiosis, it must be determined whether the miner's pneumoconiosis arose, at least in part, out of coal mine employment.[4] Third, the miner has to demonstrate he is totally disabled.[5] And fourth, the miner must prove the total disability is due to coal workers' pneumoconiosis.[6]

With those four principle conditions of entitlement in mind, the next adjudication step requires the identification of the conditions of entitlement a claimant failed to prove in the prior claim. In that regard, of the four principle conditions of entitlement, the two elements that are usually capable of change are whether a miner has pneumoconiosis or whether he is totally disabled. *Lovilia Coal Co. v. Harvey*, 109 F.3d 445 (8th Cir. 1997). That is, the second element of entitlement (pneumoconiosis arising out of coal mine employment) and the fourth element (total disability due to pneumoconiosis) require preliminary findings of the first element (presence of pneumoconiosis) and the third element (total disability).

In Mr. Johnson's case, his most recent prior claim was finally denied in December 2001 for failure to prove the presence of pneumoconiosis and total disability. Consequently, for purposes of adjudicating the present subsequent claim, I will evaluate the evidence developed since December 2001 to determine whether Mr. Johnson can now prove total disability or the presence of pneumoconiosis.

Total Disability

To receive black lung disability benefits under the Act, a claimant must have a total disability due to a respiratory impairment or pulmonary disease. If a coal miner suffers from complicated pneumoconiosis, there is an irrebuttable presumption of total disability. 20 C.F.R. §§ 718.204 (b) and 718.304. If that presumption does not apply, then according to the provisions of 20 C.F.R. §§ 718.204 (b) (1) and (2), in the absence of contrary evidence, total disability in a living miner's claim may be established by four methods: (i) pulmonary function tests; (ii) arterial blood-gas tests; (iii) a showing of cor pulmonale with right-sided, congestive heart failure; or (iv) a reasoned medical opinion demonstrating a coal miner, due to his pulmonary condition, is unable to return to his usual coal mine employment or engage in similar employment in the immediate area requiring similar skills.

While evaluating evidence regarding total disability, an administrative law judge must be cognizant of the fact that the total disability must be respiratory or pulmonary in nature. In

[3]20 C.F.R. § 718.202.

[4]20 C.F.R. § 718.203 (a).

[5]20 C.F.R. § 718.204 (b).

[6]*Id.*

Beatty v. Danri Corp. & Triangle Enterprises and Dir., OWCP, 49 F.3d 993 (3d Cir. 1995), the court stated, in order to establish total disability due to pneumoconiosis, a miner must first prove that he suffers from a respiratory impairment that is totally disabling separate and apart from other non-respiratory conditions.

Mr. Johnson has not presented evidence of cor pulmonale with right-sided congestive heart failure and the record contains no evidence of complicated pneumoconiosis. As a result, Mr. Johnson must demonstrate total respiratory, or pulmonary, disability through pulmonary function tests, arterial blood-gas tests, or medical opinion.

Pulmonary Function Tests

Exhibit	**Date / Doctor**	**Age / Height**	**FEV¹ pre[7] post[8]**	**FVC pre post**	**MVV pre post**	**% FEV¹ / FVC pre post**	**Qualified[9] pre Post**	**Comments**
DX 13	March 27, 2003 Dr. Hawkins	66 68″	1.67	2.49	80	67.1	No[10]	Mild obstructive lung defect
EX 1	October 1, 2003 Dr. Goldstein	66 67″	2.19	2.66	77	82.3	No[11]	

None of the pulmonary function studies meet the regulatory total disability standards. Therefore, Mr. Johnson cannot establish that he is totally disabled through pulmonary function tests under 20 C.F.R. § 718.204 (b) (2) (i).

[7]Test result before administration of a bronchodilator.

[8]Test result following administration of a bronchodilator.

[9]Under 20 C.F.R. § 718.204 (b) (2) (i), to qualify for total disability based on pulmonary function tests, for a miner's age and height, the FEV1 must be equal to or less than the value in Appendix B, Table B1 of 20 C.F.R. § 718, **and either** the FVC has to be equal or less than the value in Table B3, or the MVV has to be equal **or** less than the value in Table B5, or the ratio FEV1/FVC has to be equal to or less than 55%.

[10] The qualifying FEV1 number is 1.78 for age 66 and 67.7″; the corresponding qualifying FVC and MVV values are 2.28 and 71, respectively.

[11] The qualifying FEV1 number is 1.71 for age 66 and 66.9″; the corresponding qualifying FVC and MVV values are 2.21 and 69, respectively.

Arterial Blood Gas Studies

Exhibit	Date / Doctor	pCO^2 (rest) pCO^2 (exercise)	pO^2 (rest) pO^2 (exercise)	Qualified[12]	Comments
DX 13	March 27, 2003 Dr. Hawkins	40 43	99 69	No[13] No	Normal
EX 1	October 1, 2003 Dr. Goldstein	41	83	No	

Since none of the arterial blood gas studies satisfy the regulatory total disability criteria, Mr. Johnson cannot establish that he is totally disabled under the provisions at 20 C.F.R. §§ 718.204 (b) (2) (ii).

Medical Opinion

Total disability may also be established under 20 C.F.R. §718.204 (b) (2) (iv) through the preponderance of the more probative medical opinion. Under this regulatory provision, total disability may be found through reasoned medical opinion:

> if a physician exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment as described in paragraph (b) (1) of this section.

Twenty C.F.R. §718.204(b) (1) defines such employment as either his usual coal mine work or other gainful employment requiring comparable skills. To evaluate total disability under these provisions, an administrative law judge must compare the exertional requirements of the claimant's usual coal mine employment with a physician's assessment of his respiratory impairment. *Schetroma v. Director, OWCP*, 18 B.L.R. 1-19 (1993).

Based on Mr. Johnson's testimony concerning the physical requirements of his work as a trackman, I find that during his last coal mine employment, he engaged in heavy manual labor. Specifically, Mr. Johnson was required to move, drag, lift and carry several heavy items, some weighing as much as 100 pounds. Having established the physical requirements of Mr. Johnson's last coal mining job, I turn to the medical opinions on whether he is capable of returning to that type of work as a track man.

[12]To qualify for Federal Black Lung Disability benefits at a coal miner's given pCO^2 level, the value of the coal miner's pO^2 must be equal to or less than corresponding pO^2 value listed in the Blood Gas Tables in Appendix C for 20 C.F.R. § 718.

[13]For the pCO^2 of 40 to 49, the qualifying pO^2 is 61, or less.

Dr. Jeffrey Hawkins
(DX 13, DX 23, CX 2, and CX 3)

On March 27, 2003, Dr. Hawkins, board certified in internal medicine and pulmonary diseases, conducted a pulmonary evaluation of Mr. Johnson. Mr. Johnson had a 20 year history of coal mine employment as a general laborer. He never smoked cigarettes. His medical history included wheezing attacks, chronic bronchitis, arthritis and high blood pressure. Mr. Johnson complained about sputum, wheezing and shortness of breath upon exertion. An examination of the chest showed that it was normal. The chest x-ray was positive for pneumoconiosis and the pulmonary function test revealed a mild airflow obstruction. The arterial blood gas studies showed Mr. Johnson had adequate blood gas exchange. Dr. Hawkins diagnosed asthmatic bronchitis based on Mr. Johnson's dyspnea, abnormal spirometry and coughing with wheezing. He believed the cause of the bronchitis was "atopic[14]/extrinsic exposures." Based on the chest x-ray, shortness of breath, and coal dust exposure, Dr. Hawkins also diagnosed pneumoconiosis. The physician opined that Mr. Johnson should avoid further exposure to chemicals, dusts and fumes. Additionally, Mr. Johnson was "unable to perform manual labor." Dr. Hawkins attributed 60 percent of Mr. Johnson's respiratory impairment to his asthmatic bronchitis and 40 percent to his pneumoconiosis.

In a July 29, 2003 supplemental report, Dr. Hawkins summarized his earlier findings based on his March 27, 2003 pulmonary evaluation. Pulmonary function tests indicated both an obstruction and restriction in Mr. Johnson's lungs, which causes a pulmonary impairment. Notably, Mr. Johnson becomes dyspneic with more than mild exertion. As a result, the "intensity of manual labor related to coal mine work would be beyond Mr. Johnson's capacity" such that he cannot return to coal mining. Additionally, Dr. Hawkins advised that Mr. Johnson should avoid any further exposure to the chemicals, dust, and fumes associated with coal mining.

Following the pulmonary evaluation, through August 2004, Dr. Hawkins continued to see Mr. Johnson quarterly for COPD (chronic obstructive pulmonary disease), asthmatic bronchitis, CWP (coal workers' pneumoconiosis), and HTN (hypertension). During these visits, Mr. Johnson typically presented with some cough and chronic shortness of breath upon exertion. The physician also heard wheezing. A July 2003 echocardiogram produced essentially normal results. Dr. Hawkins prescribed an inhaler and other medications.[15]

Dr. Allan R. Goldstein
(EX 1)

On October 6, 2003, Dr. Goldstein, board certified in internal medicine and pulmonary diseases, conducted a pulmonary evaluation of Mr. Johnson. A non-smoker and former coal miner with 20 years of coal dust exposure, Mr. Johnson presented with shortness of breath for more than nine years, which has gotten progressively worse. At present, he is only able to walk a block to a block and a half before becoming breathless. Mr. Johnson has a history of high

[14]Allergic. DORLAND'S ILLUSTRATED MEDICAL DICTIONARY 156 (28th ed. 1994).

[15]A portion of the treatment notes are illegible.

blood pressure, a cough and significant arthritis; the arthritis having caused Mr. Johnson to stop working in the mines.

Upon physical examination, the chest sounds were clear. The chest x-ray was negative for pneumoconiosis. The arterial blood gas studies did not reveal an abnormality. The pulmonary function test established the presence of a restrictive defect, with normal profusion. The physician opined that the pulmonary restrictive defect was related to Mr. Johnson's "protuberant abdomen." In the absence of interstitial changes, Dr. Goldstein believed Mr. Johnson did not have occupational pneumoconiosis. He explained that if the restrictive defect was caused by an interstitial lung disease, the x-ray would be "distinctly" abnormal and diffusing capacity would be reduced. Therefore, Dr. Goldstein opined that the lung defect may be related to "hypertension…possible cardiomegaly, deconditioning and his body stature." It is not related to Mr. Johnson's exposure to coal dust.

Dr. A. David Russakoff
(EX 2)

On October 11, 2004, Dr. Russakoff, board certified in internal medicine and pulmonary diseases, conducted a review of the medical record, including treatment notes, radiographic chest films, medical records created for Mr. Johnson's prior claims, the medical report by Dr. Hawkins on March 27, 2003 and the medical report by Dr. Goldstein on October 6, 2003. Mr. Johnson had a significant history of coal dust exposure for 20 years. The medical history revealed arthritis, hypertension and that Mr. Johnson is a non-smoker. From his review, Dr. Russakoff concluded that from 1994 through 2000, there was no evidence of pneumoconiosis in Mr. Johnson's lungs. During that time, Mr. Johnson had poorly controlled hypertension and was developing a cardiac enlargement. An underlying asthmatic condition does not appear to have become active until 2003. Due to Mr. Johnson's weight gain since 2000 of forty-seven pounds, his worsening cardiac function, and an underlying asthmatic condition, Mr. Johnson's pulmonary function has symptomatically deteriorated and worsened. Notably, the results from an October 2003 pulmonary function test were improved from earlier values obtained in March 2003 and May 2000. Thus, Dr. Russakoff concluded that there is no compelling evidence to indicate coal workers' pneumoconiosis is present.

Dr. Russakoff does not believe that Mr. Johnson has coal workers' pneumoconiosis or any other dust-related disease of the lungs. The evidence also does not show any of the characteristic rounded regular opacities in the upper lung zones that are usually seen with coal workers' pneumoconiosis. In addition, the arterial blood gases were normal in 1994 and 1999. The deterioration in lung function after 1999 is more likely due to a combination of the underlying asthmatic condition and developing hypertensive heart disease with early congestive heart failure and not due to pneumoconiosis or coal dust exposure.

Mr. Johnson's lung disease was not caused by dust inhalation or coal mine employment. The evidence suggests that the "asthmatic lung condition and hypertensive heart disease, as well as his body habitus were the likely cause of his impaired lung function." Dr. Russakoff believes that Mr. Johnson has a pulmonary impairment and is totally disabled. Recognizing that the etiology of the impairment and disability is difficult to ascertain, Dr. Russakoff opined that the

impairment results from either: a) the combination of two separate conditions, asthma and cardiac disease; or, b) cardiac disease with a component that mimics pulmonary disease.

Discussion

The two physicians who rendered an opinion on Mr. Johnson's pulmonary capacity to return to coal mining agree.[16] Based on the obstruction and restriction in Mr. Johnson's lungs indicated by the pulmonary function test and his dyspnea, Dr. Hawkins found Mr. Johnson to be impaired from a respiratory standpoint and unable to perform manual labor, which included his last job as a laborer at the coal mine. For similar reasons, Dr. Russakoff also concluded that Mr. Johnson's pulmonary condition rendered him totally disabled. Considering the extensive manual labor associated with Mr. Johnson's trackman work and the abnormalities identified in the pulmonary function tests and clinical presentation, the consensus of Dr. Hawkins and Dr. Russakoff is well reasoned. Accordingly, I find that the preponderance of the newly developed medical opinion establishes that Mr. Johnson is totally disabled under the provisions of 20 C.F.R. § 718.204 (b) (2) (iv). That is, Mr. Johnson has proven through the medical opinion evidence developed since the denial of his prior claim that he is now totally disabled.

Issue #2 - Entitlement to Benefits

Having established that one of the conditions of entitlement that he previously failed to prove has changed and is now present – total disability – Mr. Johnson has satisfied the provisions of 20 C.F.R. § 725.309. As a result, I must now examine the entire medical record to determine whether Mr. Johnson is entitled to black lung disability benefits. As previously discussed, to receive benefits under the Act, Mr. Johnson must prove that he has pneumoconiosis that arose out of his coal mine employment and that he is totally disabled due to coal workers' pneumoconiosis.

Presence of Pneumoconiosis

"Pneumoconiosis" is defined as a chronic dust disease arising out of coal mine employment.[17] The regulatory definitions include both clinical or medical, pneumoconiosis, defined as diseases recognized by the medical community as pneumoconiosis, and legal pneumoconiosis, defined as "any chronic lung disease arising out of coal mine employment."[18] The regulation further indicates that a lung disease arising out of coal mine employment includes "any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment."[19] As courts have

[16]Dr. Goldstein did not address whether Mr. Johnson's present pulmonary condition would preclude his return to coal mining.

[17]20 C.F.R. § 718.201 (a).

[18]20 C.F.R. § 718.201 (a) (1) and (2).

[19] 20 C.F.R. § 718.201 (b).

noted, under the Act, the legal definition of pneumoconiosis is much broader than medical pneumoconiosis. *Kline v. Director, OWCP*, 877 F.2d 1175 (3d Cir. 1989).

According to 20 C.F.R. §718.202, the existence of pneumoconiosis may be established by four methods: chest x-rays (§ 718.202 (a)(1)), autopsy or biopsy report (§ 718.202 (a)(2)), regulatory presumption (§ 718.202 (a)(3)),[20] and medical opinion (§ 718.202 (a)(4)). Since the record does not contain evidence that Mr. Johnson has complicated pneumoconiosis, and he filed his claim after January 1, 1982, a regulatory presumption of pneumoconiosis is not applicable. Additionally, neither a biopsy nor obviously an autopsy report has been submitted. As a result, Mr. Johnson will have to rely on chest x-rays or medical opinion to establish the presence of pneumoconiosis.

Chest X-Rays

Date of x-ray	**Exhibit**	**Physician**	**Interpretation**
November 2, 1994	DX 1 & DX 20	Dr. Russakoff, B[21]	Negative for pneumoconiosis; borderline cardiomegaly
(same)	DX 1 & DX 20	Dr. Sargent, BCR, B	Negative for pneumoconiosis; osteoarthritis of spine
January 11, 1999	DX 2 & DX 20	Dr. Goldstein, B	Completely negative for pneumoconiosis
(same)	DX 2 & DX 20	Dr. Sargent, BCR, B	Negative for pneumoconiosis
March 30, 1999	DX 3	Dr. Bryant	Possible chronic obstructive pulmonary disease; cardiomegaly and osteoarthritis of the spine.
May 9, 2000	DX 3 & DX 20	Dr. Hasson, B	Negative for pneumoconiosis; abnormal cardiac size
(same)	DX 3 & DX 20	Dr. Sargent, BCR, B	Negative for pneumoconiosis; marked cardiomegaly; widened aorta
March 27, 2003	DX 13, CX 3	Dr. Ballard, B, BCR	Positive for pneumoconiosis, profusion category 1/0,[22] type s/t opacities;[23] mildly enlarged heart.

[20]If any of the following presumptions are applicable, then under 20 C.F.R. § 718.202 (a)(3), a miner is presumed to have suffered from pneumoconiosis: 20 C.F.R. § 718.304 (if complicated pneumoconiosis is present, then there is an irrebuttable presumption that the miner is totally disabled due to pneumoconiosis); 20 C.F.R. § 718.305 (for claims filed before January 1, 1982, if the miner has fifteen years or more coal mine employment, there is a rebuttable presumption that total disability is due to pneumoconiosis); and 20 C.F.R. § 718.306 (a presumption when a survivor files a claim prior to June 30, 1982).

[21]The following designations apply: B – B reader, and BCR – Board Certified Radiologist. These designations indicate qualifications a person may posses to interpret x-ray film. A "B Reader" has demonstrated proficiency in assessing and classifying chest x-ray evidence for pneumoconiosis by successful completion of an examination. A "Board Certified Radiologist" has been certified, after four years of study and examination, as proficient in interpreting x-ray films of all kinds including images of the lungs. *See also* 20 C.F.R. § 718.202 (a) (1) (ii).

[22]The profusion (quantity) of the opacities (opaque spots) throughout the lungs is measured by four categories: 0 = small opacities are absent or so few they do not reach a category 1; 1 = small opacities definitely present but few in number; 2 = small opacities numerous but normal lung markings are still visible; and, 3 = small opacities very numerous and normal lung markings are usually partly or totally obscured. An interpretation of category 1, 2, or 3 means there are opacities in the lung which may be used as evidence of pneumoconiosis. If the interpretation is 0, then the assessment is not evidence of pneumoconiosis. A physician will usually list the interpretation with two digits. The first digit is the final assessment; the second digit represents the category that the doctor also seriously

(same)	DX 22	Dr. Wheeler, BCR, B	Negative for pneumoconiosis; enlargement of left ventricle
(same)	DX 26	Dr. Ahmed, BCR, B[24]	Positive for pneumoconiosis, profusion 1/0, type p opacities; cardiomegaly present
October 1, 2003	CX 2	Dr. Cappiello, BCR, B	Positive for pneumoconiosis, profusion 1/0, type p opacities.
(same)	EX 3	Dr. Wheeler, BCR, B	Negative for pneumoconiosis; enlargement of left ventricle and hypoinflation of lungs
(same)	EX 1	Dr. Goldstein, B	Negative for pneumoconiosis;[25] cardiac abnormality present.
April 28, 2004	CX 3	Dr. Payne, BCR	(Negative for pneumoconiosis); no pulmonary infiltrates; cardiac silhouette not significantly enlarged

Of the seven chest x-rays in the record, no dispute exists concerning five of the films. Based either on the consensus of the evaluations or uncontested interpretations of the films, I find the following chest x-rays are negative for pneumoconiosis: November 2, 1994, January 11, 1999, March 30, 1999, May 9, 2000, and April 28 2004.

The two remaining chest x-rays generated a dispute among the experts. According to Dr. Wheeler, a dual qualified radiologist, the March 27, 2003 chest x-ray is negative for pneumoconiosis. However, his sole opinion is outweighed by the consensus of Dr. Ballard and Dr. Ahmed, also both dual qualified radiologists, that the same film is positive for pneumoconiosis. Consequently, I conclude the March 27, 2003 chest x-ray is positive.

Concerning the October 1, 2003, the more qualified experts, Dr. Wheeler and Dr. Cappiello, disagree on whether this radiographic image contains evidence of pneumoconiosis. Dr. Cappiello found the presence of pneumoconiosis; Dr. Wheeler did not. Although Dr. Goldstein also believed the chest x-ray was negative, his evaluation has less probative weight since he is only qualified as a B reader.[26] Due to the evidentiary standoff between the two dual qualified radiologists on the film's interpretation, I find the October 1, 2003 chest x-ray provides inconclusive evidence of pneumoconiosis.

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considered. For example, a reading of 1/2 means the doctor's final determination is category 1 opacities but he considered placing the interpretation in category 2.

[23]There are two general categories of small opacities defined by their shape: rounded and irregular. Within those categories the opacities are further defined by size. The round opacities are: type p (less than 1.5 millimeter (mm) in diameter), type q (1.5 to 3.0 mm), and type r (3.0 to 10.0 mm). The irregular opacities are: type s (less than 1.5 mm), type t (1.5 to 3.0 mm) and type u (3.0 to 10.0 mm). JOHN CRAFTON & ANDREW DOUGLAS, RESPIRATORY DISEASES 581 (3d ed. 1981).

[24]I take judicial notice of Dr. Ahmed's board certification and have attached the certification documentation.

[25]After being informed of the positive chest x-ray interpretation of this film by Dr. Cappiello, Dr. Goldstein reaffirmed his opinion that the chest x-ray was negative. He also stated his belief that an interpretation of 1/0 was not "strong" evidence of pneumoconiosis (EX 4).

[26]*See Zeigler Coal Co. v. Director [Hawker]*, 326 F.3d 894 (7th Cir. 2003) and *Cranor v. Peabody Coal Co.*, 22 B.L.R. 1-1 (1999) (en banc on recon.) (greater probative weight may be given to the interpretations of a dual qualified radiologist in comparison to a physician who is only a B reader.)

In summary, setting aside the inconclusive chest x-ray of October 1, 2003, the five negative chest x-rays (November 2, 1994, January 11, 1999, March 30, 1999, May 9, 2000, and April 28 2004) outweighs the single positive film (March 27, 2003). Consequently, I find the preponderance of the chest x-ray evidence does not establish the presence of pneumoconiosis and does not support a finding of pneumoconiosis under the provisions of 20 C.F.R. § 718.202 (a) (1).

Medical Opinion

Although Mr. Johnson can not establish the presence of black lung disease through chest x-ray evidence, he may still prove this requisite element of entitlement under 20 C.F.R. § 718.202 (a) (4) through the preponderance of the more probative medical opinion. Prior to summarizing the medical opinion, a review of other pulmonary function tests and the blood gas studies in the record helps place the physicians' assessments into perspective.

Additional Pulmonary Function Tests

Exhibit	**Date / Doctor**	**Age / Height**	**FEV¹ pre post**	**FVC pre post**	**MVV pre post**	**% FEV¹ / FVC pre post**	**Qualified pre Post**	**Comments**
DX 1	Nov. 2, 1994 Dr. Hasson	57 68"	2.81	3.52	119	79.8%	No[27]	Normal
DX 2	Jan. 11, 1999 Dr. Goldstein	61 68"	2.43	3.19	112	76.2%	No[28]	Minimum obstructive defect
DX 3	May 9, 2000 Dr. Hasson	63 68"	1.97	2.60	94	75.8%	No[29]	Mild restriction

[27]The qualifying FEV^1 number is 1.92 for age 57 and 67.7″; the corresponding qualifying FVC and MVV values are 2.44 and 77, respectively.

[28]The qualifying FEV^1 number is 1.86 for age 61 and 67.7″; the corresponding qualifying FVC and MVV values are 2.37 and 74, respectively.

[29] The qualifying FEV^1 number is 1.82 for age 63 and 67.7″; the corresponding qualifying FVC and MVV values are 2.34 and 73, respectively.

Additional Arterial Blood Gas Studies

Exhibit	Date / Doctor	pCO_2 (rest) pCO_2 (exercise)	pO_2 (rest) pO_2 (exercise)	Qualified[30]	Comments
DX 1	Nov. 2, 1994 Dr. Hasson	34.4 36.0	94.6 90.0	No[31] No[32]	Normal
DX 2	Jan. 11, 1999 Dr. Goldstein	34.4	86.8	No	
DX 3	May 9, 2000 Dr. Hasson	32.4 30.6	91.2 91.6	No[33] No[34]	Normal

Additional Medical Opinion

Dr. Jack Hasson
(DX 1)

On November 2, 1994, Dr. Hasson conducted a pulmonary evaluation of Mr. Johnson, who had been a coal miner for twenty years and never smoked cigarettes. Mr. Johnson presented with complaints of sputum, dyspnea, and cough. The x-ray did not show the presence of pneumoconiosis. The pulmonary function test was normal and the arterial blood gas study was essentially normal. Dr. Hasson diagnosed hypertensive cardiovascular disease with an "idiopathic" etiology and chronic bronchitis with an "intrinsic" etiology. Dr. Hasson did not believe that the chronic bronchitis caused any pulmonary impairment in Mr. Johnson's lungs.

On May 9, 2000, Dr. Hasson again conducted a pulmonary evaluation of Mr. Johnson. Mr. Johnson worked in the coal mines for 20 years. He never smoked. He complained of sputum, wheezing, dyspnea and cough. The x-ray did not show the presence of pneumoconiosis. The pulmonary function test revealed a mild restriction and the arterial blood gas study was normal. Dr. Hasson concluded that Mr. Johnson did not have coal workers' pneumoconiosis. He diagnosed hypertension/cardio-vascular disease with an "idiopathic" etiology and asthmatic bronchitis with an "intrinsic" etiology. The physician opined that the hypertension/cardio-vascular disease causes Mr. Johnson's moderate impairment.

[30]To qualify for Federal Black Lung Disability benefits at a coal miner's given pCO_2 level, the value of the coal miner's pO_2 must be equal to or less than corresponding pO^2 value listed in the Blood Gas Tables in Appendix C for 20 C.F.R. § 718.

[31]For the pCO_2 of 34, the qualifying pO_2 is 66, or less.

[32] For the pCO_2 of 36, the qualifying pO_2 is 64, or less.

[33]For the pCO_2 of 32, the qualifying pO_2 is 68, or less.

[34]For the pCO_2 of 30, the qualifying pO_2 is 70, or less.

Dr. Allan R. Goldstein
(DX 2)

On January 11, 1999, Dr. Goldstein conducted a pulmonary evaluation of Mr. Johnson. Mr. Johnson worked in the coal mines for almost 20 years and never smoked cigarettes. He complained of sputum, wheezing, dyspnea and cough. The physical examination was normal and the chest x-ray was negative for pneumoconiosis. The pulmonary function test revealed a mild obstructive defect. The EKG was abnormal. Based on his examination, Dr. Goldstein diagnosed hypertension and shortness of breath. The physician indicated the shortness of breath might be caused by hypertension. He attributed the abnormal pulmonary function test result to possibly asthma. In his opinion, Mr. Johnson had a minimal pulmonary function impairment.

Dr. Thomas Bryant
(DX 3 and DX 20)

On March 30, 1999, Dr. Bryant treated Mr. Johnson. He diagnosed cardiomegaly and possible mild chronic obstructive pulmonary disease. In February 2001, Dr. Bryant treated Mr. Johnson for uncontrolled hypertension and also diagnosed osteoarthritis. At that time, the physical examination of the chest was normal.

Discussion

On the issue of whether Mr. Johnson has pneumoconiosis, the physicians to consider his case disagreed. Dr. Hasson, Dr. Goldstein, Dr. Bryant and Dr. Russakoff did not find the presence of pneumoconiosis in Mr. Johnson's lungs. Dr. Hawkins, on the other hand, diagnosed Mr. Johnson with coal workers' pneumoconiosis. Due to this conflict of medical opinion, I must assess the probative value of the respective opinion in terms of reasoning and documentation.

As to the first factor, a physician's medical opinion is likely to be more comprehensive and probative if it is based on extensive objective medical documentation such as radiographic tests and physical examinations. *Hoffman v. B & G Construction Co*., 8 B.L.R. 1-65 (1985). In other words, a doctor who considers an array of medical documentation that is both long (involving comprehensive testing) and deep (includes both the most recent medical information and past medical tests) is in a better position to present a more probative assessment than the physician who bases a diagnosis on a test or two and one encounter.

The second factor affecting relative probative value, reasoning, involves an evaluation of the connections a physician makes based on the documentation before him or her. A doctor's reasoning that is both supported by objective medical tests and consistent with all the documentation in the record, is entitled to greater probative weight. *Fields v. Island Creek Coal Co.,* 10 B.L.R. 1-19 (1987). Additionally, to be considered well reasoned, the physician's conclusion must be stated without equivocation or vagueness. *Justice v. Island Creek Coal Co.,* 11 B.L.R. 1-91 (1988).

With these principles in mind, I first observe that although Dr. Bryant was a treating physician, his assessment was presented through terse treatment notes. Thus, the absence of any explanation for his diagnoses reduces the probative value of his opinion. This insufficiency

becomes more notable considering that while Dr. Bryant believed Mr. Johnson might be struggling with chronic obstructive pulmonary disease, the physician did not indicate the suspected cause of the pulmonary affliction.

Dr. Goldstein twice evaluated Mr. Johnson and presented a well reasoned opinion concerning the presence of medical pneumoconiosis. However, his opinion loses some probative value due to his apparent focus on medical pneumoconiosis in explaining why Mr. Johnson's pulmonary problem was not due to coal dust exposure. Specifically, the physician indicated that if Mr. Johnson's pulmonary restriction were due to occupational pneumoconiosis, the chest x-ray would be abnormal. While that statement may make medical sense, his analysis conflicts with the definition of legal pneumoconiosis, which does not require the presence of a positive chest x-ray for diagnosis.[35]

Having evaluated Mr. Johnson twice, Dr. Hasson had a firm documentary basis for his assessment. However, his opinion loses probative value due to the dated nature of his examinations. Since Dr. Hasson last examined Mr. Johnson in 2000, he has not rendered an assessment on whether the recent deterioration in Mr. Johnson's lung function may be related to coal dust exposure. Additionally, Dr. Hasson's terse conclusions on the U.S. Department of Labor examination forms offer little in the way of explanation for his findings.

As Mr. Johnson's treating physician, with repeated contacts including a full pulmonary evaluation, Dr. Hawkins had an excellent, and perhaps the best, documentary foundation for his pulmonary diagnosis. Nevertheless, his opinion loses probative value due to the absence of a sufficient explanation for his pneumoconiosis diagnosis. On the pulmonary examination form, Dr. Hawkins listed three factors that lead to his coal workers' pneumoconiosis diagnosis: a positive chest x-ray, Mr. Johnson's shortness of breath, and his coal mine employment history. Since I have previously determined that the preponderance of the chest x-ray evidence is actually negative for pneumoconiosis, Dr. Hawkins' diagnosis would remain viable only if he explained how the characteristics of Mr. Johnson's breathing difficulties, or other aspects of the pulmonary examination or treatment notes also helped him identify coal dust as a causation factor. Although Dr. Hawkins subsequently provided further explanation concerning the extent of Mr. Johnson's disability, he did not also describe how the nature of the breathing impairment isolated coal dust as an etiology. Similarly, his terse treatment notations provide no insight on how Mr. Johnson's shortness of breath supported a diagnosis of pneumoconiosis.

As the only physician to consider the entire medical record, Dr. Russakoff presented a well documented medical opinion, even though he was not a treating physician. Based on that extensive documentation, Dr. Russakoff has presented a well reasoned medical opinion that Mr. Johnson does not have coal workers' pneumoconiosis or any other dust-related disease of the lungs. The physician attributes the recent deterioration in Mr. Johnson's lung function after 1999 to his underlying asthma, developing heart disease and body condition rather than coal dust inhalation or coal mine employment. His documented and reasoned explanation linking Mr. Johnson's pulmonary impairment to his heart condition, asthma and body stature rather than his coal mining is also most consistent with the other medical documentation in the record. Dr.

[35] *See* footnote 18.

Russakoff's well reasoned assessment based on extensive documentation enhances the relative probative value of his medical conclusion that Mr. Johnson does not have pneumoconiosis.

In summary, due to documentation and reasoning deficiencies, the assessments of Dr. Bryant, Dr. Goldstein, Dr. Hasson, and Dr. Hawkins have diminished probative value. In contrast, Dr. Russakoff's well documented and reasoned medical opinion has greater relative probative weight and establishes that Mr. Johnson does not have pneumoconiosis. Additionally, Dr. Russakoff's more probative medical opinion outweighs the sole contrary opinion of Dr. Hawkins. As a result, the preponderance of the more probative medical opinion does not support a finding of pneumoconiosis under 20 C.F.R. § 718.202 (a) (4).

CONCLUSION

By demonstrating through probative medical opinion that he has become totally disabled from a pulmonary perspective, Mr. Johnson has established the requisite change in condition since the denial of his prior claim in December 2001. However, upon consideration of the entire record, I find that neither the preponderance of the chest x-rays nor more probative medical opinion establish the presence of pneumoconiosis. Accordingly, since he has failed to prove this requisite element for entitlement of black lung disability benefits, Mr. Johnson's subsequent claim for benefits must be denied.

ORDER

The claim of Mr. HABERT J. JOHNSON for benefits under the Act is **DENIED**.

SO ORDERED:

A

RICHARD T. STANSELL-GAMM
Administrative Law Judge

Date Signed: February 23, 2005
Washington, DC

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481 (2001), any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 days from the date this decision is filed with the District Director, Office of Worker's Compensation Programs, by filing a notice of appeal with the Benefits Review Board, ATTN.: Clerk of the Board, Post Office Box 37601, Washington, DC 20013-7601. See 20 C.F.R. § 725.478 (2001) and § 725.479 (2001). A copy of a notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits. His address is Frances Perkins Building, Room N-2117, 200 Constitution Avenue, NW, Washington, DC 20210.

Attachment No. 1

American Board of Medical Specialties

Certification:

Afzal Uddin Ahmed, MD

Certified by the American Board of Radiology in:

Diagnostic Radiology

American Board of Medical Specialties
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